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ILLINOIS STATE TREASURER'S OPPORTUNITY ILLINOIS: HOSPITAL LOAN PROGRAM APPLICATION

APPLICATION TO PARTICIPATE IN THE TREASURER'S OPPORTUNITY ILLINOIS: HOSPITAL LOAN PROGRAM
This form is to be completed by an authorized representative of the organization seeking to borrow funds from a financial institution for a project that is eligible for support under the Opportunity Illinois: Hospital Loan Program sponsored by the Office of Illinois State Treasurer Alexi Giannoulias. This form should be completed with the assistance of the financial institution that will be the lender. The information on this form will allow the Treasurer's Office to determine eligibility for participation in the program. ***Please type all requested information. Use separate sheets and cite section numbers where appropriate.***

Section 1

APPLICANT/FINANCIAL INSTITUTION INFORMATION

1.1 Briefly describe the use of the deposit: _____
_____

1.2 Applicant Information:
Applicant Name: _____
Address: _____
City, County, State, Zip: _____
Fein Number: _____
Contact Person: _____ Title: _____
Phone Number: _____ Fax Number: _____ E-mail Address: _____
How did you hear about this program? _____

1.3 Financial Institution:
Institution Name: _____
Address: _____
City, County, State, Zip: _____
Contact Person: _____ Title: _____
Phone Number: _____ Fax Number: _____ E-mail Address: _____

Section 2

PROJECT/LOAN INFORMATION
Please type the following information on separate sheets, as needed, in the following format. Use the section numbers provided.

2.1 Project Information:
2.1.1 Provide a detailed description of this organization and purpose of this project. Please attach a mission statement that identifies the hospital's commitment to serving the health care needs of the community and specify the date it was adopted.
2.1.2 Provide the most recent Community Benefits Plan and specify the date it was adopted. The plan must include the goals and objectives for providing community benefits including charity care and government sponsored indigent health care, identify populations and communities served by the hospital, and disclose health care needs that were considered in developing the plan.
2.1.3 Location of the project (Street, City, County and Zip Code).
2.1.4 Description of the benefit to the people of Illinois.
2.1.5 Detailed description of the proposed use of the funds requested.
2.1.6 Provide a brief explanation why other loan financing is not adequate and why the Treasurer's linked deposit is the necessary incentive for the project to be implemented.

2.1.7 Report Charity Care: Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid and other federal, state or local indigent health care programs, eligibility for which is based on financial need. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 worksheet C, Part I, PPS Inpatient ratios), and not the actual charges for the services. Attach a copy of the current charity care policy and specify the date it was adopted.
Charity Care $_____

2.1.8 Report of community benefits actually provided other than charity care.
Language Assistant Services $_____
Government Sponsored Indigent Health Care $_____
Donations $_____
Volunteer Services
Employee Volunteer Services $_____

Non-Employee Volunteer Services $_____
Education $_____
Government-sponsored Program Services $_____
Research $_____
Subsidized Health Services $_____
Bad Debts $_____
Other Community Benefits $_____
Please attach a schedule for any additional community benefits not detailed above.

2.1.9 Attach audited financial statements for the last two years.
2.1.10 For a Non-profit Organization, attach a 501©(3), non-profit certification letter from the Illinois Secretary of State or tax-exempt letter from the IRS.

2.2 Financial Information:
2.2.1 Term of deposit: (2 year maximum initial deposit with a possible 3-year renewal) _____
2.2.2 Amount of deposit requested: (deposit amount cannot exceed loan value) $_____
2.2.3 Additional funding sources and amounts: List if applicable (i.e. equity, grants, loans, etc.)
Source: Amount:
_____ $_____
_____ $_____
2.2.4 Total cost of project: (Including this deposit request and additional funding sources) $_____

2.3 Funding Information:
2.3.1 Property Acquisition: (Attach a fully executed sales contract.) $_____
2.3.2 Construction/Leaseholder Improvements: (Attach contractor's cost estimates.) $_____
2.3.3 Equipment/Machinery: (Attach price quotes from vendors.) $_____
2.3.4 Total: $ _____

Section 3

CERTIFICATIONS & ACKNOWLEDGEMENTS
By signing below the applicant agrees and certifies as follows:

- The State Treasurer's Office may withdraw the deposit and the financial institution may accelerate repayment of the loan if the borrower fails to satisfy all of the requirements of the Opportunity Illinois: Hospital Loan Program.
- Neither the applicant, nor an immediate family member of the borrower, is a director, officer or employee of the financial institution or the State Treasurer's Office.
- The applicant understands that all information and documentation regarding the State Treasurer's Employ Illinois: Hospital Loan Program is public information. The State Treasurer's Office may release any information provided to it by the applicant and may also release any information regarding the approval or rejection of the application.
- The applicant understands that the State Treasurer's Office may reject any application for any reason at its sole discretion.
- The applicant will allow signage - provided by the Treasurer's Office - to be displayed at the project site listing contact information regarding this program.
- Borrower acknowledges that the Treasurer's Office may perform site visits at the project location for compliance purposes. Borrower also agrees to cooperate with the Treasurer's Office in carrying out the site visit.
- I certify, to the best of my knowledge, that the foregoing statements and the information I have provided are true and complete. I shall promptly notify the Illinois State Treasurer's Office of any changes in the information provided. I understand that a false or incomplete statement may result in the Treasurer's Office withdrawing the deposit and the financial institution accelerating the repayment of the loan without penalty and both entities seeking any other available relief. **I also understand that an individual who provides a false statement may be subject to criminal prosecution under the Illinois Criminal Code (720 ILCS 5 et seq.).**

Applicant Signature: _____ Title: _____

Print Name: _____ Date: _____

Please return this completed application and Project/Loan Information (from Section 2) to:

Illinois State Treasurer Alexi Giannoulias
Opportunity Illinois: Hospital Loan Program
100 West Randolph Street, Suite 15-600
Chicago, Illinois 60601
Phone: (312) 814-1244 • Fax: (312) 814-3716

www.treasurer.il.gov

Printed by the Authority of the Treasurer of the State of Illinois. kp Revised – February 15, 2008

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